Johns Hopkins Medicine Alliance for Patients, LLC
MDCTO-0102
Summary Information

Maryland Primary Care Program, 2018 Application Cycle

CTO Overview

CTO Information	
Application ID Number	MDCTO-0102
Status of the Proposed CTO	The proposed CTO is owned and operated by a healthcare organization and is currently in existence.
Organization Site Name	Johns Hopkins Medicine Alliance for Patients, LLC
DBA Name	Johns Hopkins Medicine Alliance for Patients, LLC
Website (if applicable)	https://www.hopkinsmedicine.org/alliance_patients/
Ownership & Legal Structure	
Owned by Health Care Organization	Yes
Name of Parent Organization	Johns Hopkins Health System
Legal Structure	Jointly owned by Johns Hopkins University and Johns Hopkins Health System
Service Area	
Counties Served	Anne Arundel County; Baltimore County; Baltimore City; Carroll County; Charles County; Frederick County; Harford County; Howard County; Montgomery County; Prince George's County; Washington County
Partnerships	
Formal Partnerships	JHM has extensive ongoing relationships with many community-based organizations such as schools, faith communities, and social service providers. Examples include Regional Partnerships; Sisters Together And Reaching; Men and Families Center; Local Health Improvement Coalitions (e.g. Baltimore City, Howard County); Horizon Foundation; Howard County Health Department; Howard County Office on Aging and Independence; Healthcare for the Homeless, The Coordinating Center/WiSH Program and many others.
Informal Partnerships	N/A
Services Offered	
Tele-diagnosis	Currently in place
Tele-behavioral health	Currently in place
Tele-consultation	Currently in place
Remote Monitoring	Currently in place
Other	Currently in place
HIT	
CRISP Connectivity	We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).; We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.; We use CRISP to view data.; We send administrative encounter data to CRISP on a regular basis.; We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis.
HIT Vendor	Epic
HIT Product Name	Hyperspace, Healthy Planet

Care Team Members

Category	Currently in place: How many?	Planned for future: How many?
Administrative Support	2	3
Behavioral Health Counselor	7	10
Billing/Accounting Support	N/A	1
Care Managers - RNs	13	N/A
Care Managers - Medical Assistants	N/A	N/A
Care Managers - Licensed Social Worker	1	N/A
Community Health Workers	4	N/A
Data Analysts	5	7
Health IT Support	6	8
Licensed Social Workers	N/A	N/A
Nutritionist	N/A	N/A
Pharmacists	1	2
Practice Transformation Consultants	4	N/A
Psychiatrist	1	N/A
Psychologist	N/A	N/A
Quality Improvement	2	N/A

Vision

In 2014, the Johns Hopkins University School of Medicine (JHSOM) and the Johns Hopkins Health System (JHHS), launched "Johns Hopkins Medicine Alliance for Patients, LLC", (or "JMAP") as a Track 1 Accountable Care Organization (ACO) through the Medicare Shared Savings Program. The mission of JMAP is to unite Johns Hopkins Medicine (JHM) with non-JHM providers and to accelerate healthcare transformation so as to improve the quality of care and reduce unnecessary healthcare expenditures. This collaboration of primary and specialty providers utilizes care coordination teams, IT and data infrastructure, and value-based incentives to drive clinical integration across the continuum. JMAP has benefited from expertise from Johns Hopkins HealthCare, the managed care arm of JHM, as well as the Johns Hopkins Home Care Group, who delivers a variety of home and community based programs. JHM and JMAP are now creating a Care Transformation Organization (CTO) in accordance with the Maryland Primary Care Program (MDPCP) to service both JHM primary care as well as other partner practices. The CTO will utilize JMAP's existing infrastructure to offer customizable care delivery, IT, and quality improvement solutions to partner practices to realize value in care transformation. This process will be highly collaborative with partner practice leadership and front line primary care providers with the goal of promoting provider engagement in the process. By design, the CTO will systematically assess the gaps and opportunities for each partner practice and draw from a central infrastructure and expertise in practice transformation to deploy appropriate services. This may include multi-disciplinary care coordination teams either embedded in partner practice sites or who service the geographic region based on a balance of practice needs and regional considerations. These will include designated care managers and other care coordination staff (behavioral health as an example) that will assume accountability for appropriate program activities. Additionally, enhanced primary care services for remote patient monitoring of chronic disease, home-based services, and utilization of telehealth or other health IT solutions may be available to enhance the care experience. The CTO will offer support to practices with predictive analytics to assist in the optimal deployment of care coordination resources and to guide practices to focus on their own high-cost, high need patients. In addition, providers can directly refer patients to a central clinical screener who can triage to the most appropriate care team and resources. The care team completes a comprehensive risk assessment and creates an individualized care plan for the most vulnerable patients, including those that are high-need with multiple chronic conditions. To facilitate transitional care, the CTO will help PCP practices utilize CRISP to obtain real-time alerts from ENS on hospital admissions, emergency department visits, and transfers to skilled nursing facilities. The CTO's care team members will collaborate directly with providers involved in caring for the patient to ensure safe and effective transitions to the next level provider. JHM has also recently launched a skilled nursing facility collaborative that will further support post-discharge activities. Quality improvement (QI) efforts will be supported through collaboration with partner practices assuring the highest level of quality and achieving improved performance in all aspects of care delivery. Highly experienced clinical QI teams will collaborate with practices to ensure performance targets are met. Using its existing ACO infrastructure and leveraging the expertise of the JHM enterprise, the CTO will provide a comprehensive and patient-centered approach to improving care for the Medicare populations of participating partner practices.

Approach to Care Delivery Transformation

The CTO will rely heavily on JHM expertise with practice transformation, implementation of new care delivery models, and deploying a variety of care team resources to achieve MDPCP program goals. Recognizing that each primary care practice may have unique strengths and opportunities with achieving care delivery transformation goals, the CTO will deploy practice transformation consultants who will follow a stepwise approach to assessing gaps and outlining an implementation plan to meet program requirements. To foster practice engagement, the CTO will also routinely engage with practice leadership including on site direct observation and review of workflows and setting and monitoring goals. The CTO will assist practices with a process of 1) identification of high-cost, high-need persons using the Johns Hopkin ACG system; 2) assessment of individual physical and mental health, social needs; and 3) apply culturally appropriate behavior change techniques in the development of strategies and an individualized care plan to improve health and enhance self-management skills. The composition of the care management team will reflect the identified needs and may include an assigned care manager, home visiting clinician, community health worker, health behavior specialist (HBS), pharmacist or other care team member, as appropriate, leveraging telephonic and remote monitoring. The HBS, with psychiatry oversight, can be deployed to partner sites using the primary care behaviorist model, where they focus on assisting patients with medical and social complexity in conjunction with comorbid psychiatric disease. The care team may also include informal caregivers, lay health advocates, memory care coordinators, neighborhood navigators and other community resources available in local regions. In addition, acknowledging that patients are members of communities and socio-environmental contexts, the CTO will engage with community-based organizations to expand our reach and services.